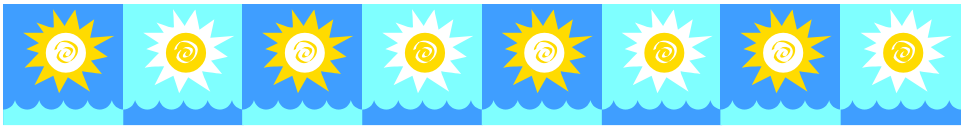
First Steps

UTS TRAINING TIMES

Volume 7 Issue 2 May 2011

Inside this issue....

- After a rocky start, the Indiana General Assembly passed a new two-year budget and adjourned on time. The budget bill included several changes for the First Steps System. These are outlined on the back cover.
- Dawn Downer, First Steps Director has answered many of the questions on the minds of SPOEs, SCs and providers. We hope that this will become a regular feature of the Training Times. Please submit your questions to training@utsprokids.org using the subject line Downer.
- Summer is just around the corner. As the weather warms up, many providers move their therapy sessions outdoors to the backyard and community playgrounds. Make sure you review the playground safety checklist and share it with your families.
- June 19th is Father's Day. The article on Father's Care may give you a new perspective on fathers' involvement and influence in their children's lives. Try to engage the fathers of the children you serve during therapy sessions and with specific activities that fathers can do with their children.
- In April, NECTAC published a fact sheet on the Importance of Early Intervention. It reinforces the belief that early intervention is more effective and less costly when it is provided earlier in life rather than later.



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Direct Service Provider (new to First Steps December 2007 and after)	First Steps Orientation or DSP 101—Provider Orientation Course (self-study)	DSP 102 - 1/2 day within 3-6 months of enrollment (on-site) DSP 103 - 1/2 day within 6-12 months of enrollment (on-site) Quarterly (4) - Training Times Assessment (self-study) First Steps Core Training—one course per credential year (self study or on-site) 10 or 15 points for initial credential
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Attention: New Providers and Service/Intake Coordinators

The Bureau of Child Development Services requires all providers and service coordinators to complete the quarterly *Training Times* assessment as part of your mandatory training requirements for credentialing.

New providers must establish an account on the UTS website (**http://www.utsprokids.org**) to register for UTS trainings. Obtaining an account is easy.

1. Click the Account Login in the upper right hand corner.
2. On the login page click on Create One Here
3. Enter your information (note that UTS Training Times is mailed to your primary address—you are encouraged to use your home address, especially if it is difficult to get personal mail at your workplace, e.g. hospital system). UTS does not give any of your training profile information to anyone outside of First Steps. The BCDS and UTS will periodically send you email updates regarding First Steps.
4. When all information has been entered click the Update Information.
5. Register for your annual training fee.
6. Once your payment has been posted, you can take the Training Times assessment, under My Quizzes.
7. If you have questions or encounter problems email Janice in the UTS Connect office at: **registration@utsprokids.org**

Indiana First Steps
UTS Training Times
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Web Address: http://www.utsprokids.org

Email: Training questions training@utsprokids.org

Registration questions: registration@utsprokids.org

Service Coordinator Training Dates for 2011

Service Coordination 102: All service coordinators must enroll and complete SC 102 3- 6 months after employment date. If you are unable to adhere to this timeline, you must request a training waiver. Email your request to training@utsprokids.org.

Tuesday **August 16, 2011** **ProKids, Inc. Indianapolis** **9-4pm**

Service Coordination 103: All service coordinators must complete SC103 6-12 months after employment date. If you are unable to adhere to this timeline, you must request a training waiver. Email your request to training@utsprokids.org.

Tuesday **September 20, 2011** **ProKids, Inc. Indianapolis** **9-4pm**

All Service Coordinators must register online for SC 102 and SC 103 at **www.utsprokids.org** .

DSP 102 and DSP 103 New Provider Follow Up Orientation

All newly enrolled providers must complete the DSP series 101, 102 and 103 within the first year of their enrollment. DSP 101 is required for provider enrollment. DSP 102 must be completed three to six months following the provider enrollment date and DSP 103 must be completed six to twelve months following the provider enrollment date. Completion dates for these courses must be documented on the Annual Attestation Statement. The training dates for DSP 102 & 103 are listed below. Usually these trainings are held on the first Tuesday of each month at ProKids Inc. Since there are specific timelines for completion of DSP 102 and DSP103, that allow time for experience in the First Steps System, **providers may NOT take both courses on the same day.**

DSP 102 Dates	Time	DSP 103 Dates	Time
June 7, 2011	1:00-4:00 PM	June 7, 2011	9:00-12:00 PM
July 12, 2011	1:00-4:00 PM	July 12 2011	9:00-12:00 PM
August 2, 2011	1:00-4:00 PM	August 2, 2011	9:00-12:00 PM
September 6, 2011	1:00-4:00PM	September 6, 2011	9:00-12:00PM

AEPS 2-DAY Certification Course

This course provides a 2 day, comprehensive overview of the Assessment, Evaluation and Programming System (AEPS) for Infants and Children. The AEPS is a criterion-referenced developmental assessment tool for children, birth to six years. This course is required for all ED Team members. The 2-day AEPS course may also be used as a First Steps Core Training (FSCT) for your First Steps initial or annual credential. **Cost: $75**

May 17 & 18, 2011 **August 4 & 5, 2011**

Check the UTS website for future AEPS training dates: www.utsprokids.org

Additional Opportunities for Credential Points

Providers may utilize trainings (on-site and self-study) and conferences outside of UTS to meet their initial or annual credential points as long as the training is related to provider or service coordinator competencies and it is relevant to infants through age 6. These may include training offered at the SPOE Provider Meetings, association conferences (APTA, ASHA, etc.), hospital based conferences or grand rounds, other local, regional and national conferences, and books, videos and online training. You must keep a copy of the agenda or brochure that includes date, speakers, an agenda/content information and the time spent in the sessions you attended or a one page summary of the self-study training in your credential file. More information on credentialing can be found in the recently revised Personnel Guide at

http://www.eikids.com/in/matrix/docs/pdfs/First_Steps_Personnel_GuideRevised_12-2010.pdf

20 Questions for Part C Director, Dawn Downer

Recently Dawn Downer took time out from her busy schedule to answer some questions posed by First Steps SPOEs, SC and providers. If you have additional questions that you would like Dawn to address in future issues, please email them to training@utsprokids.org, using the subject line Downer.

1. **How do you feel the transition to Provider Agencies has gone?**

   Remarkably well. That is not to say that there were not a few bumps in the road. However, with the help of many dedicated agencies and individuals, we were able to enroll over 1,300 providers under agencies in a very short time period.

2. **What were the greatest challenges? What are the successes?**

   The biggest challenge has definitely been making the changes to enrollment and service delivery while maintaining as much consistency as possible for families. We have also worked diligently to meet aggressive timelines in the review and approval of Provider Agency applications and provider enrollment.

   I would say that the biggest success that we have experienced is the increased awareness of how the First Steps program operates, how it is funded and how the community has rallied to help. We are also very pleased with some of the feedback from families and providers describing a more multidisciplinary approach to service delivery.

3. **There were rumors that many providers left the system, is this true?**

   There were individual providers that made personal decisions to not remain with the First Steps System. However, at this point, we have approximately 100 additional providers that have joined First Steps in 2011.

4. **Do all service areas in the state have an adequate number of providers? What is the state doing to assist clusters and agencies in meeting the needs of the local cluster?**

   While availability of providers has improved, First Steps continues to have areas of the state that have fewer providers than desirable. It is hopeful that the agency involvement and the design of the service areas will continue to improve the availability of services in rural areas. The state is continuing to work with the local programs to review service areas and access to service. In addition, the State will be working with Provider Agencies in identifying strategies to increase productivity of their providers.

5. **Why were some providers not required to join a provider agency, while all DT, OT, PT and SLPs were required to join a provider agency?**

   In looking at the provision of services to children in First Steps, there are a few "low incident" services. These providers, such as Social Workers are in low demand and work across many counties. The requirement for them to join an agency would have resulted in individuals joining several or all agencies within specific service areas. Because of the small number of providers, the requirement could have eliminated some Agency's ability to provide services, as they may not have been able to hire or contract with a provider. In addition, providers like Audiologists and Psychologists are frequently employed by hospitals who are not within a First Steps network.

6. **Are there other changes planned for this year? If so, what? Will provider fees be cut again?**

   At this time, the state is busy reviewing the current changes and the fiscal impact. It is our hope that the continued implementation of the changes will assist us in meeting our financial targets for the next fiscal year. There are a few new strategies for increasing revenue on the horizon. We are working to put into place the capitated rates for insurance billing. This new legislation is anticipated to bring in an additional $4m. In addition, we will be working with Agencies to implement strategies to increase insurance reimbursement for families where the capitated rate does not apply. Increase collaboration with other programs is also a goal for 2012.

7. **Have you heard from families regarding the transition to provider agencies? What is their response?**

   We have had both positive and negative feedback from families. Most families are very understanding of the financial situation and deeply want the program to continue for future families. We have also had the occasional call or email from a family that is upset that their provider will not be continuing as their provider. For most of these families, it is the feeling of losing a relationship that is the most difficult. We have also had a handful of emails from families upset because the high intensity services that they have received through First Steps are not approved for continuation. We are working with those families and the SC to identify other resources to access the services that their child medically needs. We have also heard from families who are very pleased with the changes. There is excitement in the coordination of care and teamwork and families are truly starting to see the benefits.

8. **Will all providers continue to require state approval prior to enrollment?**

   Yes, as in the past, providers will submit (through their agency) enrollment documentation. The state will review the provider information and make final determinations about the enrollment.

9. **Do you foresee any changes in service coordination? There have been rumors that SC caseloads are increasing and others report that they are being limited?**

   Service Coordination is the key to the early intervention system and is always changing to meet the needs of the families and the system. However, we do not foresee any "big" changes. With the passing of the insurance legislation, there may be some changes to forms and information shared with families. We are also hoping for changes to the provider matrix and how provider information is shared. The new grant applications put into place caseload limits for Service Coordinators. While we have some extraordinary service coordinators, it is truly not realistic to believe that they can consistently carry high caseloads and continue to do a quality job.

10. **Has First Steps met its financial goals for the year? What is the financial outlook going forward?**

    First Steps started off the year with a projected $17million deficit. DDRS and the First Steps staff, working with stakeholders, put together a plan anticipated to close the funding gap to $8m. At this time, we are near target for meeting our goal. Stay tuned…

11. **Are insurance companies reimbursing FS? How does this year's total compare to last year's?**

    First Steps does receive reimbursement from many private insurance plans. However, reimbursement is not consistent and there are more denials than payments. The program budgeted for $4.8m in TPL revenue. At this time, we are projected to receive slightly less than the amount budgeted.

12. **Where do you stand on high intensity (more than 1 hour and multiple disciplines per week) services?**

    Services over one hour or more than 1 time per week should be an exception, rather than the rule. When teams are thinking about higher levels of services, they should take into consideration what other services the child is receiving, has the team attempted to modify the existing services to better meet the child's needs, what are the goals to decrease the service…. Services should not be increased to replace medical services or because the team is trying to provide a more intense service delivery due to the child approaching age 3.

13. **Whose role is it to monitor high intensity requests?**

    The Provider Agency, ED team and SC should monitor these requests. In addition, the State is also tracking and monitoring requests.

14. **What if the family disagrees with state PA denial? Can they file a complaint or appeal it?**

    Families may appeal decisions regarding service recommendation.

15. **Are families paying their cost participation and how is this impacting the program finances?**

    Approximately 80% of the families with a copay pay their bill within a timely manner.

16. **How many families have had their services suspended due to failure to pay cost participation?**

    Approximately 15 families per month are subject to suspension. Many of these families are near age 3 or feel comfortable with their child's development and choose to leave the system. Families that do not agree with their copay or the bill may request a review. Families agreeing to a payment plan will also not be suspended from service.

17. **If agencies are responsible for training its providers, will the TT and FSCTs continue to be required?**

    Yes, at this time, there are no anticipated changes to the training or credentialing requirements.

18. **Do you have a preference for service delivery models?**

    Providers should select service delivery models that work for the individual family and child. Family involvement and education should be included in all models of delivery, as well as utilization of best practices and strategies that are researched based.

19. **Is Indiana considering a change to any particular model?**

    No

20. **Indiana has always had a good national reputation, how does Indiana rank now with other states?**

    Indiana continues to maintain an exemplary program nationally. Our Annual Performance Report consistently shows high compliance with federal requirements.

LAST DAY TO CLAIM INDEPENDENT AUTHS 6/30/11

Regardless of the authorization end date, no independent, self-employed providers of DT, OT, PT, or SLP may bill for services provided as an independent provider after 6/30/11. Providers of other First Steps services (Audiology, Medicine, Nursing, Psychology, Social Work and Vision) may continue to receive authorizations and bill as an independent as long as they maintain referral agreements with one or more provider agencies.

Effective Team Functioning

The Individualized Family Service Plan (IFSP) is intended to be developed and implemented by a team of people, including the family, service coordinator and service providers. During the IFSP planning process, the team members should engage in an explicit discussion of how the team can "best" operate in order to be most effective.

Effective Team Functioning Requires:

- Up-to-date knowledge and skill in own discipline
- Knowledge of each other's expertise/past experiences
- Time together to develop at least adequate work relationships based on trust and respect
- Systematic (known, routine, flexible) communication, that includes face-to-face, written and electronic means
- Mutually-agreed upon goals/agenda for every contact/interaction
- Willingness of all members to focus on the family/child's needs and not their own agenda
- Confidence in each member for what they can offer to the team process/goals
- Comfort in asking for help and offering help
- Willingness to ask for clarification
- Capable of occasionally filling in for absent team member on some tasks
- Good communication skills for listening, interviewing, explaining, coaching
- Willingness and skill to engage in mutual problem-solving

Teams can evaluate their performance by completing a team evaluation at http://www.ifspweb.org/evaluation.html. Adapted from http://www.ifspweb.org/team_functioning.html

Mandatory Use of the New Progress Report Form Begins 7/1/11

The state has set 7/1/11 as the date in which all providers must begin using the new progress report form. Providers can locate the form on the state website. The form is available in two versions - MS Word and Adobe PDF. The word version is accessible at http://www.in.gov/fssa/files/Progress_Report_2011.doc and the PDF version is accessible at http://www.in.gov/fssa/files/Progress_Report_2011.pdf.

Instructions for these forms are also available. Please note that these forms are to be sent to the SPOE electronically on first of the month due. You can locate the Progress Report Due chart and information about the forms at http://www.in.gov/fssa/files/PRdirections_2011.pdf or you can review the chart and information in the February 2011 edition of the Training Times.

Many providers are already using the new form. If you would like to submit comments and/or suggestions for improvements, please email First Steps at FirstStepsWeb@fssa.in.gov. Please include Progress Note Comments in the subject line. Revisions to the form will be considered over the next six months.

Fisher-Price® - Let's Play! Project for Children with Special Needs

Fisher-Price® has developed a partnership with experts from the Let's Play! Projects, a federally funded program that supports family play experiences and activities for children with special needs. http://www.fisher-price.com/US/special_needs/default.asp

Third Party Documentation for Therapies

Most Insurance companies (third party payers) have specific guidelines for service documentation. Here is an overview compiled from several insurance companies' guidelines.

Therapy Evaluation:
A comprehensive evaluation is essential. This will include a review of all baseline data to establish a treatment plan and develop goals based on the data. Most third party payers require an evaluation before implementing any therapy service. Rarely is a specific assessment tool required, but the evaluation should include:

- objective, measurable and functional descriptions of an individual's deficits, including relevant diagnoses, signs/symptoms and conditions.
- an analytic interpretation and synthesis of all data, including a summary of the baseline findings in a written report.
- a summary of clinical reasoning and consideration of contextual factors with recommendations.
- a plan of care with specific treatment techniques or activities to be used in treatment sessions.
- the frequency and duration of the sessions and of the treatment plan of care.
- functional, measurable and time-framed long term and short term goals based on appropriate and relevant evaluation data.
- Prognosis for improvement
- A discharge plan this in initiated at the start of services
- Many plans require a physician order and a statement of medical necessity
- Signature and title of evaluating therapist

Treatment session documentation:

- Date of treatment
- Specific treatment(s) provided that match the procedure codes billed
- Total treatment time
- The individual's response to treatment
- Skilled ongoing assessment of the individual's progress towards goals written in objective, measurable terms
- Any new changes or concerns regarding the plan of care
- Signature and title of treating therapist

Progress Reports:

- The date services were initiated
- Time period covered by the progress report
- All medical and therapy diagnoses and conditions treated
- Statement of the individual's functioning level at the beginning of the progress report period
- Statement of the individual's current functioning level as compared to the initial evaluation and the prior progress report (objective measures of the individual's function that relate to the treatment goals:
    1. Changes in prognosis and why
    2. Changes in plan of care and why
    3. Changes in goals and why
    4. Consultation with other professionals or coordination of services, if applicable
    5. Signature and title of treating therapist

Reevaluation:
A reevaluation is indicated when there are new clinical findings, a rapid change in the individual's status or failure to respond to therapy interventions. A reevaluation is not the same as an ongoing assessment of progress. It is more comprehensive and includes all of the components of the initial evaluation. (Some third party payers require a reevaluation at set periods (i.e., at the end of an authorization period, every month, six months, annually).

First Steps providers can include all of the required third party payer documentation for evaluation, treatment sessions and progress notes within the following First Steps required forms:

- Evaluation/Reevaluation - ED Team Assessment Summary Report
- Treatment Session - Face-to-Face form
- Progress Note - Evaluation/Progress Report

The Importance of Early Intervention

for Infants and Toddlers with Disabilities and their Families

Fact sheet prepared by NECTAC
April 2011

The Infants and Toddlers with Disabilities Program (Part C) of the Individuals with Disabilities Education Act (IDEA) was created in 1986 to enhance the development of infants and toddlers with disabilities, **minimize potential developmental delay**, and reduce educational costs to our society by minimizing the need for special education services as children with disabilities reach school age.[1] Part C provides early intervention (EI) services to children aged birth to three with developmental delays or a medical condition likely to lead to a developmental delay. Some states also serve infants and toddlers who are at heightened risk for developmental delay due to biological/medical factors or their environmental/caregiving circumstances.

The Part C program recognizes that **families play a crucial role** in optimizing their child's development and aims to enhance the capacity of families to meet the special needs of their infants and toddlers. Services are based on an Individualized Family Service Plan (IFSP) that is jointly developed by family members and service providers, taking into account the child's developmental needs and the family's concerns and priorities.

Part C recognizes that infants and toddlers with disabilities have a right to receive services in their home or in other community places and programs that are available to all young children. This assures that learning takes place during **everyday activities with familiar people** in typical settings, which best supports early development.

In 2009, Part C served 348,604 children nationally.[2] Part C is not intended to be a stand-alone program. The intent is to **build interagency partnerships** among state agencies and programs in health, education, human services and developmental disabilities.

Why Intervene Early?

Decades of rigorous research show that children's earliest experiences play a critical role in **brain development**. The Center on the Developing Child at Harvard University has summarized this research:[3,4]

- Neural circuits, which create the foundation for learning, behavior and health, are most flexible or "plastic" during the **first three years** of life. Over time, they become increasingly difficult to change.
- Stable **relationships** with caring and responsive adults, safe and supportive **environments**, and appropriate **nutrition** are key elements of healthy brain development.
- Early social/ emotional development and physical health provide the foundation upon which **cognitive and language skills** develop.

These findings underscore the critical importance of intervention in the earliest years. Positive early experiences are essential prerequisites for later **success in school, the workplace, and the community**.

What are the Benefits?

High quality early intervention services can change a child's developmental trajectory and improve outcomes for children, families, and communities. Services to young children who have or are at risk for developmental delays have been shown to **positively impact outcomes across developmental domains**, including health,[4] language and communication,[5-9] cognitive development[10,12] and social/emotional development.[8,10,11]

Families benefit by being able to better meet their children's special needs from an early age and throughout their lives.[10,12] Benefits to society include reducing economic burden through academic success[3,10,13] and a **decreased need for special education**.[13]

continued on next page

Unmet Needs in Early Intervention

There is a **high need** for good quality Part C early intervention programs.

- **More children are in need of services** than are currently being served. In 2009, 2.67% of the general population of children birth to 3 received early intervention,[2] while research indicates that as many as 13% have delays that would make them eligible[14] under criteria states commonly use.
- Research also indicates a need to **serve children earlier**. At 9 months of age, only 9% of children who have delays that would make them eligible actually receive services; at 24 months of age only 12% receive services.[15]

IDEA requires referral to Part C for any child under the age of 3 who is identified as affected by illegal substance abuse, or is involved in a substantiated case of child abuse or neglect.[1]

- Approximately **10-11% of all newborns have prenatal substance exposure**, a risk factor for poor developmental outcomes. An estimated **90-95% of these infants are sent home at birth without being identified or referred for services**.[16]
- In 2009, 702,000 children experienced **substantiated abuse or neglect**; 40% of these children received no post-investigation services; **one third were under age four**, and **infants under the age of 1 were the most likely to be victims**.[17] These young children often have **high rates of physical, cognitive, social-emotional, relational and psychological problems**.[18,19]

Take Home Message

- High quality early intervention programs for vulnerable infants and toddlers can **reduce the incidence of future problems** in their learning, behavior and health status.
- There is an urgent and substantial need to identify as early as possible those infants and toddlers in need of services to ensure that intervention is provided when the **developing brain is most capable of change**.
- Intervention is likely to be **more effective and less costly** when it is provided earlier in life rather than later.

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This paper may be downloaded from: http://www.nectac.org/~pdfs/pubs/eifactsheet_2pg.pdf

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UNC FPG CHILD DEVELOPMENT INSTITUTE

NECTAC is a program of the FPG Child Development Institute at The University of North Carolina at Chapel Hill.

KEY CONSIDERATIONS FOR SUCCESSFUL THIRD PARTY REIMBURSEMENT

1. Families should know that insurance is consistently being billed for First Steps Audiology, OT, PT and SLP services. DT services are ***NOT*** billed to insurance and always remain the family's responsibility, if they have a co-payment.
2. Families need to know what is covered by their private insurance policy. *This is a family responsibility*. All insurance subscribers should receive a handbook that outlines coverage. If the family cannot locate their insurance coverage information, they should contact their employer or Human Resources department.
3. The CRO does not automatically resubmit denied insurance claims. It is the family's responsibility to contact their insurance company and the CRO when they receive an insurance Explanation of Benefits (EOB) notice that a claim has been denied. Families who fail to contact their insurance and the CRO (if resubmission is requested), risk non-payment of services due to untimely filing. It is the family's responsibility to appeal any denied claims with their insurance company in a timely manner. Neither First Steps nor the CRO can appeal a claim on the family's behalf.
4. Providers need to understand what information third party payers need to authorize and pay therapy claims. Providers should use this information in their evaluations, face-to-face session notes and progress reports. Providers must always address goals and progress in their notes. It is often helpful to break down outcomes into long and short term goals. Progress notes can address the short term goals that have been achieved, while working towards the long term goals and the ultimate outcome or discharge goal (which usually indicates services no longer needed).
5. Providers may be asked to submit evaluations, face-to-face forms, progress notes and other information in order for insurance to process a child's claim for their services.
6. Providers should use the most appropriate ICD9 and CPT codes for the services they provide. The primary ICD9 code used should be directly related to the condition that the therapist is treating during the session. This is seldom the primary diagnosis code for the child. For example, a therapist is not treating Down Syndrome; but they may be treating a condition associated with it (hypotonicity, dysphagia, speech delay, etc.).
7. If the physician has not provided documentation of a diagnosis code that is known, the therapist can ask for it via fax, phone or email. When asked for a diagnosis/ICD9 code most physician offices will provide you with the one used for the child's last visit and *gastroenteritis* will not get your therapy reimbursed. If you know the code you want, provide it for them.
8. Licensed therapists, as defined by their individual licensure and practice act may identify signs, symptoms and conditions that may be used as the treating diagnoses. Therapist are responsible for knowing what codes (both ICD9 and CPT) they can use.
9. When 2 therapies occur on the same day and use the same CPT code, a modifier or additional information is often required.
10. In the world of third party payers, perseverance pays off—when first you don't succeed try, try again.

Save-the-Date for the 2011 ITSI Institute

September 8-9, 2011 * Ft. Harrison State Park, Indianapolis, IN

UTS Training Opportunities

FSCT—EHDI and Audiology in Indiana—May 13, 2011 1:00-4:00pm in Indianapolis, IN
The Ins and Outs of Direct Early Intervention: What Audiologists Need to Know, Reimbursement Issues for Audiology
Recent changes in referral processes and Indiana statistics will be shared. Other topics to be covered include: What to look for in early intervention services and third party reimbursement issues for the audiologist.

FSCT Child Abuse 101: Indicators of Abuse and Neglect May 17, 2011 Marion, IN; June 10, 2011 Corydon, IN; June 21, 2011 Indianapolis, IN; August 26, 2011 Valparaiso, IN; September 27, 2011 Indianapolis, IN
Understand the indicators of child maltreatment, the risk factors for maltreatment, and reporting laws and responsibilities. Prevent Child Abuse Indiana presenters: Sandy Runkle, MSW and Carol Poole, MSW.

FSCT - Hey Kids, Let's Play! June 10, 2011 and September 9, 2011 Indianapolis, IN
From the authors of Mommy the T.V.'s Off…Now What? This training targets Service Coordinators and Developmental Therapists new to early intervention, highlighting infant and toddler development, atypical development, and activities and strategies in providing First Steps services.

FSCT – Understanding Diversity within Families July 27, 2011 Indianapolis, IN
Identify individual beliefs and biases related to your own culture. Determine action steps towards developing cultural sensitivity that can be integrated into your work. Recognize cultural differences and report how you value them in relation to families and have an opportunity to talk about the aspects of recognizing the importance of fathers and their roles within the family structure.

FSCT It's Online, but Can I Trust It? May 20, 2011 Newburg, IN; June 3, 2011 Indianapolis, IN; June 24, 2011 Indianapolis, IN; July 22, 2011 Terre Haute, IN; July 29, 2011 Indianapolis and August 19, 2011 Marion, IN.
Who do you trust? Find out how to identify authoritative sources while developing a toolkit of go-to resources for education and health information. Christina Wray is from Center for Disability Information and Referral through the Indiana Institute on Disability and Community
Seminar Objectives:
1. Identify authoritative sources online.
2. Develop a toolkit of free online resources in health and education.
3. Learn how to utilize InSPIRE to access scholarly works in your subject area.

FSCT – Literacy into Therapy - TBA
All early interventionists play a vital role in the development of the infants and children we service. As providers, we not only affect a child's current development, we also have the ability to shape a child's future academic and social success. Incorporating literacy into therapy goals allows us as providers to meet the developmental needs, abilities and interests of the children we serve. This training session is an interactive look for all disciplines on why and how literacy can be incorporated into oral language, gross and fine motor and social activities.

FSCT Grief- Facilitating Acceptance

June 29, 2011,	9-12:00 PM,	Indianapolis/ProKids;
August 3,2011	9-12:00 PM	Bloomington/Location TBD
September 1, 2011	9-12:00 PM	Fort Wayne/Location TBD

This three hour seminar will focus on the stages of grieving, nature of the loss, effects on the family dynamics and facilitating acceptance- a holistic model for grieving while working with families in the Early Intervention system. Lara has a unique role as a parent of a child with special needs and provider of rehabilitation services in the Early Intervention system. The seminar will include personal and situational examples of grief. Additionally, support resources will be provided to be shared with families that providers are working with directly. Lara De Poy, MSOTR is the mother to three boys, Jackson (10) with Cerebral Palsy, Owen (7) and Isaac (4). She is also the Program Director at the Jackson Center for Conductive Education and specializes in the treatment of sensory integration/sensory processing disorders, neurological and orthopedic disorders, and early intervention and developmental delay.

Upcoming Face-to-Face FSCT: AEPS Courses
May 17& 18, 2011 and August 4 & 5, 2011 – AEPS 2-Day Certification Course
July 22 2011– FSCT – AEPS: An Overview (Onsite)

Available Online First Steps Core Trainings
Need a quick course for credentialing, check out these online offerings available 24/7.
FSCT – AEPS: An Overview
FSCT – A Family-Centered Approach to Procedural Safeguards
FSCT – Direct Service Provider Refresher Course
FSCT – Providing EI Supports and Services in Everyday Routines, Activities, and Places
FSCT – Understanding and Implementing Positive Transitions for Children and Families in Early Intervention

30 to 36 Months

Your Child's Development

Older toddlers are full of personality and energy. They want to know the reason for everything, which is why you may hear your child ask *Why* a lot!
What kinds of questions is your child asking? What is she curious about?

What Your Toddler Can Do	What You Can Do
My body helps me do "big kid" stuff now! • I can pedal a tricycle. • I can dress myself with your help. • I can draw a line. • I can turn a knob or unscrew a cap.	**Let your child scribble with markers and crayons.** This builds early writing skills. **Give your child chances to practice more advanced physical skills** like pedaling and climbing. **Child-proof again** so that your child's new ability to open caps and doorknobs doesn't lead to danger.
I use language to express my thoughts and feelings. • By age 3, I may use as many as 900 words. • I understand sentences with two or more ideas (*You can have a snack when we get home*). • I ask questions. • I know my first and last name.	**Introduce new words to build your child's vocabulary:** *Is your snack scrumptious?* **Ask questions that require more than a yes-or-no answer:** *Where do you think the squirrel is taking that nut?* **Be patient with your child's *Why* questions.** Ask him what he thinks before you answer.
I am using my new thinking skills to solve problems. • I can remember what happened yesterday. • I act out my own stories. • I'm becoming a "logical thinker." When I am pretending that it is bedtime for Teddy, I put a blanket on him and sing him a lullaby.	**At dinnertime or before bed, talk with your child about her day.** This builds memory and language skills. **Encourage your child to use logic in everyday situations:** *It's raining. What do we need in order to stay dry?*
My friends are very important to me. • I like playing with other children. I may have one or two close friends. • I notice how people are the same and different—like their skin color and size.	**Help children deal with conflicts around sharing and turn-taking:** *There is only one train. I will put the timer on and you will each have 5 minutes to play with it. While you wait for your turn, you can choose to play with cars or another toy.* **Help your child be sensitive to differences among people:** *Yes, people do come in all different sizes.*

ZERO TO THREE
National Center for Infants, Toddlers, and Families

As you use this resource, remember that your child may develop skills faster or slower than indicated here and still be growing just fine. Talk with your child's health care provider or other trusted professional if you have questions.

Your family's cultural beliefs and values are also important factors that shape your child's development.

For more information on parenting and child development, go to: **www.zerotothree.org**.

Your Child's Development

30 to 36 Months

Spotlight on Making Friends

Between 30 and 36 months, toddlers really enjoy playing with friends—doing things like acting out stories, building together with blocks, or exploring the playground.

Friendships are great fun. They also help children develop important social skills like taking turns, sharing, and helping others.[1] Through friendships, children learn to communicate with others, resolve disagreements, and understand others' thoughts and feelings.[2] Children who are friendly, confident, and who can cooperate with others are most likely to succeed in a classroom setting.

Keep in mind that brothers and sisters are often a child's first friends, even though it may not seem like it some days! Sibling relationships provide daily practice with sharing and cooperating. They also offer children opportunities to show compassion and loving support.

What's on Your Mind

My 33-month-old son has such an imagination. He wants me to call him "King Diego" and he spends all his time building castles with his blocks. Should I be worried?

Playing pretend is very common for older toddlers and preschoolers, which is a really good thing. Why? Because using their imaginations helps young children develop their thinking, language, and social skills as they talk about and think through how their story should unfold. By taking on different roles, your son is also learning to see the world from another person's point of view. By acting out stories, he is learning how to solve problems like how to build the block castle so it won't fall down. Long story short, there is no need to worry and actually many reasons to celebrate King Diego. So take a moment to get down on the floor with your son and ask what part you can act out—Queen? Soldier? Horse? You'll be having fun together and helping your son learn at the same time.

What You Can Do

Make time for play. Encourage brothers, sisters, and cousins to play together. Organize playdates with friends. Join a parenting group or attend community events like library story hours.

Give nonverbal feedback. Give your child an encouraging smile when he is unsure about sharing.

Notice positive behavior. *You two figured out how to share the trains. Nice job!*

Help children understand others' feelings. *Janelle is covering her face. She doesn't like it when you throw the ball so hard. Let's roll it gently instead.*

Encourage children to problem-solve. *You both want the tricycle. What can we do about this?*

Suggest problem-solving strategies. *How about while Marco has a turn on the tricycle, you pretend to be the traffic light and say "stop" and "go?" Then you two can switch.*

What can you do to help your child learn to be a good friend?

Did You Know…

The more television 3-year-olds watch each week, the more they ask for the foods they have seen advertised.[3]

What It Means for You:

Young children are influenced by what they see on television. So limit your child's TV time and try to avoid shows with advertisements. Make sure that what she *does* watch is right for her age. And begin teaching your toddler good eating habits by offering healthy meals and snacks. You can also be a role model by eating healthy yourself. Most importantly, keep the whole family active by making time for active play every day.

ZERO TO THREE
National Center for Infants, Toddlers, and Families

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www.zerotothree.org

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Photo credit: Eyewire/Parenting Today/Getty Images

Father's Care--Involvement, Influence and Affection: Three Keys to Father-Child Relationships

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Though they may sometimes find it difficult to express their feelings, most fathers care about their children and families. In a 1980 Gallup poll, six out of ten fathers said their families were "the most important element of my life at this time." Only 8 percent said their families were unimportant to them. When asked what they found most satisfying about their families, fathers rated "children," "closeness," and "being together" as personally important.[1]

This hearty endorsement of family life contradicts some of the traditional roles or popular images of fathers in our society:

- ***The Wallet***: This father is preoccupied with providing financial support for his family. He may work long hours to bring home his paycheck and does not take an active part in caring for the children. Making money provides this father with a distraction from family involvement.
- ***The Rock***. This is a "tough" father--strict on discipline and in charge of the family. He may also believe that a good father remains emotionally distant from his children, so expressions of affection are taboo.
- ***The Dagwood Bumstead***: This father tries to be a "real pal" to his children, but his efforts are often clumsy or extreme. He doesn't understand his children and feels confused about what to do. He may also feel that he is not respected within the family.

These traditional stereotypes are now clashing with another image of a father:

- ***The Caregiver***: This father tries to combine toughness with tenderness. He enjoys his children but is not afraid to set firm but fair limits. He and his wife may cooperate in childrearing and homemaking.

This type of father has always been around. But the number of men who choose this role is increasing. Many fathers today recognize that family life can be rewarding and that their children need their involvement.

This shift in roles is influenced by two major social changes: the increase in the number of women working and the rising divorce rate. As more and more mothers join the work force, fathers are being asked to take on more responsibilities at home. In 1979, 40 percent of the mothers of children under age 3 were employed.[2] Instead of remaining on the fringe of family life, many fathers are helping more with child care and housekeeping.

Fathers are also profoundly influenced by the escalating divorce rate.[3] For every two marriages there is now one divorce-a tripling of the divorce rate between 1960 and 1980. If they are not directly involved in a divorce, most men have friends who are. They witness the loss their friends have experienced and reexamine the importance of their own family relationships. Remarriage and step-fathering are also creating new challenges for many fathers.

Because of these changes in our society, many men are being forced to develop family relationships that are quite different from those they had with their own fathers. They cannot easily fall back on their own childhood experiences for guidance. What worked very well for their fathers 20 or 30 years ago may not work at all with the kinds of challenges fathers face today.

These changes in social attitudes mean that men have more options for meeting their obligations as fathers and husbands. Some men will express their feelings more openly, while others will be more reserved; some will enjoy the companionship and play of very young children while others will prefer involvement with older sons and daughters. Fathers do not have to try to fit a certain stereotyped pattern.

According to sociologist Lewis Yablonsky, a man's fathering style is influenced by some or all of the following forces: his enthusiasm for being a father, his own father's behavior, the images of how to be a father projected by the mass media, his occupation, his temperament, the way family members relate to each other, and the number of children he has.[4] No single style of fathering or mothering, no matter how ideal it appears, is right for everyone.

Regardless of their personal style, most fathers are interested in having a satisfying relationship with their children. Although they might not be able to put it into words, most fathers know they are important to their children.

According to psychotherapist Will Schutz, a good relationship needs three things: involvement, respect and influence, and affection.[5]

Involvement: The Foundation of a Relationship - The first step in any relationship is the feeling by both persons that the other is interested in them and wants to be with them. Many fathers begin to prepare for this kind of relationship before their child is even born. A father who seeks involvement is interested in his wife's pregnancy and makes preparations for the child's birth. When the child is born he is eager to hold the infant. In countless small ways this father demonstrates involvement--he may gently touch and play with his children, hold and talk to them. By doing these things he sends a clear and emphatic message: *I want to be your father. I am interested in you. I enjoy being with you. You and I have a relationship that is important to me.* Every child wants to sense this type of involvement from his or her father and mother. Without it, a child feels isolated and rejected. The foundation of the relationship crumbles.

What the Research Shows[6] - Research on father-child involvement demonstrates that:

- Fathers are significant for children;
- Fathers are sensitive to children;
- Fathers play with children differently than mothers do.

Fathers are significant. One researcher, Michael Lamb of the University of Michigan, found that 7 to 13-month -old children reacted equally to separations from both parents. When their fathers left, the children would cry and complain just as much as when their mothers left.

Other studies found that children can recognize pictures of their fathers at a very early age. By 15 months of age, about 25 percent of the children responded with "daddy" when they were shown his picture and by 18 months all children identified the pictures correctly. A much smaller percentage could use "mommy" as a reference to their mothers' pictures. The researchers thought the children learned to use the word "daddy" correctly because mothers talked more frequently about "daddy" than about themselves. Mothers helped to make fathers significant.

Fathers are sensitive. Fathers are as sensitive to their infants as are mothers. Research shows that fathers will make adjustments in their conversations with young children by slowing their rate of speech, using shorter phrases, and repeating words and phrases when talking to newborn infants. Fathers also demonstrate sensitivity to their infants' distress during feeding by stopping, looking more closely, and talking quietly to soothe their discomfort. Fathers can also discriminate between different types of infant crying patterns--those that express hunger, pain, or anger. In a number of studies, fathers demonstrated a sensitivity like that of mothers. The idea that mothers are inherently more responsive than fathers and more competent in child care is a myth.

Fathers' play is different. Studies have shown that fathers and mothers generally play differently with their young children. Fathers tend to be more physical and arousing in their play (especially with sons) while mothers are more verbal and tend to emphasize traditional play and games. With infants, for example, mothers are likely to speak softly, repeat words and imitate infant sounds. In contrast, fathers are more likely to be tactile and physical as they move the infant's hands and feet and touch with a rhythmic pattern. Fathers' play reveals an underlying expectation of a playful response from their babies.

These differences in play continue as the child grows older. Fathers may vigorously bounce and lift a 1- or 2-year-old in rough and tumble physical play; mothers may prefer to play conventional games like "peek-a-boo," offer an interesting toy, or read. Fathers' play appears to be more physically stimulating while mothers are more interested in teaching.

As a result, children seem to prefer fathers as play partners though in a stressful situation they may be more likely to turn to their mothers. This preference could be due to fathers spending a greater *proportion* of their time playing with their children than mothers. One researcher noted that about 40 percent of a father's time with his young children was spent in play in contrast to about 25 percent of the mother's time. Even though fathers may spend less total time in play than mothers, their type of play and their apparent interest in that type of involvement make them attractive play partners.

There are, of course, exceptions to this pattern. Some men simply do not enjoy playing with children, and some mothers may prefer an arousing, physical form of child play. Also, when both parents work, the additional demands on the family could affect the amount of time one or both parents spend enjoying their children.

Suggestions for Fathers - How can fathers become more involved with their children? First, they can give each of their children *exclusive attention* as often as possible. During their time together fathers could enjoy their children's company without allowing outside distractions to interfere. As a result, their children would feel noticed and special.

There is no single formula for how this might be accomplished. A father and child might play, talk, learn a skill or read together. What is important is that they notice each other and acknowledge a common interest. This type of undistracted attention promotes a sense that each is important to the other.

Fathers might also give their children a glimpse of their work world. Children want to know what life is like outside the home and what their parents do at work. Many farm families and small businesses include their children in the operation at an early age. Parents in other occupations may find it more difficult to give their children a glimpse of their work, but even brief visits or tours will help. Business and industry are gradually beginning to acknowledge that many workers are parents too, and that adjustment in this role can have a positive effect on work performance. Some industries provide day care centers for children of their employees. Both mothers and fathers are able to visit their children during breaks.

Influence: Building the Relationship - Once involvement is established in a relationship, influence is the next step. Each person wants to feel that what he or she says or wants is important to the other. Each wants to be listened to and included in discussions and decisions. This sense of personal power promotes feelings of self-worth and respect for the other person.

Influence is an important issue in parent-child relationships. Fathers as well as mothers want their children to listen to them and to obey their limits. Occasionally parents have to exert control over their children's behavior. They may allow no debate over whether a child can stick gum on furniture, play with matches, or sit on the car while someone is underneath changing the oil.

While parents have to be reasonably firm at times, there are occasions when they might yield to their children's wishes and grant permission for safe, enjoyable activities. Giving children privacy, letting them choose their own clothes, and allowing them to make their own purchases with their allowances are examples of giving influence to children.

When they show respect for their children's wishes but also set and maintain reasonable limits, parents send another clear and emphatic message: *I care enough about you to provide you with the guidance you must have to grow up to be a happy and responsible person. I will use my strength to protect and nurture you. But I am also interested in what **you** think is important for yourself. I will gradually let you make more and more decisions on your own so that by the time you reach adulthood, you will be able to care fully for yourself. I respect you and I know I am worthy of your respect.*

Children want their parents to be strong. They need to feel protected from a sometimes threatening world and from their own immaturity and loss of control. But they do not want to be overwhelmed by their parents' dominance. For their own self-respect, children need a measure of personal influence.

What the Research Shows - Research on father-child *influence* demonstrates that:

- Children typically have viewed fathers as more rigid, threatening, and demanding than mothers.
- Fathers usually are stricter than mothers and more likely to punish children, but mothers may use a wider variety of punishments.
- Mothers who take authority in decision-making in the home seem to have a marked effect on boys, lowering their sons' tendency to imitate their fathers and thus their masculine orientation. Father-dominance, on the other hand, does not lower the femininity of girls.
- Fathers' involvement in setting limits and making decisions increases their influence in the family, especially with their sons.
- Moral judgment is at a low level in boys and girls who view their father's control as overly dominant.
- Children may experience personal problems and difficulty in school if they are frequently dominated and punished by their fathers.
- Delinquent boys are likely to have fathers who are controlling, rigid, and prone to alcoholism. These fathers may use physical punishment as a form of discipline and they tend to be inconsistent and erratic in their childrearing techniques.

Suggestions for Fathers - Children both admire and fear their father's strength. On one hand they want their father to be strong and powerful (in the sense of being self-confident and determined) but they may also be frightened at times by that power. Walking the middle ground between dominance and permissiveness can sometimes

be difficult for a father.

How can fathers establish a sense of influence? First, they can establish and maintain reasonable limits for their children.[7] Children respect parents who provide firm but gentle guidance. But they also benefit from parents who gradually allow them to make decisions on their own.

Fathers could also be responsive to their children's interests. Instead of always telling them what to do, fathers could listen and be responsive to their children's suggestions whenever possible. When shopping, for example, a father might let his 5-year-old choose one or two stores to visit. Similarly, a father might ask his son or daughter to suggest a game to play or a movie to see.

There are times, though, when children do not have these kinds of choices. Parents often have to have the final word. The goal might be to achieve an appropriate balance of influence in the relationship.

Affection: The Relationship Deepens - When people feel accepted and respected in a relationship, they will begin to develop close feelings of mutual affection. Parents who are never involved with their children and are either too permissive or too dominant are not likely to become close to their children. Fathers who expect to be constantly vigilant disciplinarians who show no tenderness create a climate of coldness that puts distance in their relationships. Sometimes the effect can be painful.

Following a presentation to a community group, the speaker was approached by a man who wanted to ask a question about his adult son. He said that he and his boy had never been close. He was, in his words, the typical busy father who disciplined his kids but didn't show them much affection. Not long ago he suffered a heart attack and was not expected to live. When his son visited him in the hospital room they experienced a moment of intimacy that the father found deeply rewarding. For the first time in their lives both men expressed their love for each other. The words, "I love you, Dad" meant a great deal to this very sick father. Following his recovery, however, he realized he was gradually slipping back into his old patterns of coldness and isolation.

"How can we tell each other about our good feelings?" he asked. The threat of death made this man more aware of the emptiness that existed between him and his son. He was struggling with the idea that although change would be difficult there was hope if he was willing to take risks and make the effort.

By expressing affection through words and deeds, parents send another clear and emphatic message to their children: *I want to be close to you; I love you. You are special to me. I am willing to share myself so you can get to know me better. You give me joy.*

In our closest relationships we seek these bonds of affection. Talking about these feelings has traditionally been easier for women than for men, but, like the father in the previous example, men are beginning to acknowledge the importance of intimacy and affection. They also are more willing to express the softer, gentler side of themselves.

What the Research Shows - Research on father-child affection demonstrates that:

- Generosity in preschool boys was more likely when they viewed their fathers as nurturant, affectionate, and comforting.
- Altruism in children grades 3 to 6 was more likely when their fathers participated in caring for them during infancy.
- Loving fathers who provide reasonable, firm guidance without arbitrarily imposing their will promote competence in their children. Unloving, punitive, authoritarian fathers tend to produce dependent, withdrawn, anxious and dejected children.
- Warm, accepting fathers tend to have children with high self-esteem. Alienated adolescents view their parents as hostile and non-accepting.
- Warm, affectionate fathers influence the development of their children's sex-role behavior; they also have a positive influence on achievement and peer popularity in boys and personal adjustment in girls.
- Adolescent daughters recalled less affection and support from their fathers than the fathers recalled expressing. Daughters wished they had received, and fathers wished they had given, more affection and support.[8]
- Adolescent boys who thought they were similar to their fathers were likely to be popular with their peers.

- Adolescent boys were more likely to be similar to their fathers when the fathers were perceived as rewarding, gratifying, and understanding. These same boys usually scored high on the masculinity scale of the questionnaire.
- Mothers are more interested in the nursing and care of newborns when fathers are emotionally supportive.

Suggestions for Fathers - A parent-child relationship might be compared to a bank account. Every negative act--a frown, a slap, a "no" or "I'm busy"--is like a withdrawal from the account. In contrast, affectionate, caring actions are like deposits in the relationship account. If the withdrawals exceed the deposits, the relationship breaks down into mutual distrust and isolation it becomes bankrupt. Fathers who have to make a large number of withdrawals can do so if their deposits of warmth, support and nurturance are high enough. Fathers can be both tough when necessary and tender when needed.

Tenderness can be difficult for some fathers because of its association with sexuality. One expectant father was concerned that he could have difficulty expressing affection if he had a son. He thought he might feel uncomfortable kissing and hugging a little boy. As it turned out, a son was born and he and his father are affectionate and close. The new father felt no hesitancy about expressing his feelings. Some fathers may become uncomfortable with expressing affection to adolescent daughters. This unfortunate association of affection with sexuality can deprive people of the closeness they deeply need in their relationships.

There are many ways in which men can express their affection for their children. Some may feel comfortable talking with their children. Others may let their actions reveal their feelings. Some expressions, like hugging, are obvious while others, like quiet self-sacrifice, are more subtle. There is a danger in letting our actions speak for themselves: subtle forms of affection can easily be overlooked or misinterpreted. Words can enrich what we do by making our actions more easily understood by others. Children sometimes need to hear their father say "I love you" to fully appreciate what he does for them. On the other hand, words not backed by action may sound hollow and false. Every father will develop his own style of showing affection in his relationships with others in his family.

Few events will change a man s life as much as becoming a father. Being a father can be both frightening and frustrating. For many fathers, nothing makes them more angry than a defiant, stubborn child. Being entrusted with the responsibility for the care of another person can be an awesome task. But the opposite can also be true. Nothing may give a father more pleasure than to see his children gradually grow into adulthood, to have his affection returned in good measure and to have his deepest feelings of self-worth confirmed. Regardless of the mask they sometimes wear, whether it be one of casual aloofness or macho toughness, fathers' feelings for and about their children run deep. ***Fathers care***.

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6. The research conclusions identified in this publication were selected from the following books: Michael Lamb, *The Role of the Father in Child Development* (New York: John Wiley, 1981); David B. Lynn, *The Father: His Role in Child Development* (Monterey, CA: Brooks/Cole, 1974); Ross D. Parke, Fathers (Cambridge: Harvard University Press, 1981).

7. Charles A. Smith, *Effective Discipline* (Manhattan, KS: Cooperative Extension Service, 1979/ 1980). Ask for publication numbers C-604, C-604a and C-621.

8. My thanks to Dorothy Martin, Extension Family Life Specialist in Colorado, for sharing the results of her study titled, "The Expressive Domain of the Father-Adolescent Daughter Relationship Defined by Their Perceptions and Desires." Available from Dissertation Abstracts International, Vol. XXXIX, Number 11, 1979.

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Public Playground Safety Checklist

Here are 10 important tips for parents and community groups to keep in mind to help insure playground safety.

1. **Make sure surfaces around playground equipment have at least 12 inches of wood chips, mulch, sand, or pea gravel, or are mats made of safety-tested rubber or rubber-like materials.**

2. **Check that protective surfacing extends at least 6 feet in all directions from play equipment. For swings, be sure surfacing extends, in back and front, twice the height of the suspending bar.**

3. **Make sure play structures more than 30 inches high are spaced at least 9 feet apart.**

4. **Check for dangerous hardware, like open "S" hooks or protruding bolt ends.**

5. **Make sure spaces that could trap children, such as openings in guardrails or between ladder rungs, measure less than 3.5 inches or more than 9 inches.**

6. **Check for sharp points or edges in equipment.**

7. **Look out for tripping hazards, like exposed concrete footings, tree stumps, and rocks.**

8. **Make sure elevated surfaces, like platforms and ramps, have guardrails to prevent falls.**

9. **Check playgrounds regularly to see that equipment and surfacing are in good condition.**

10. **Carefully supervise children on playgrounds to make sure they are safe.**

SAVE THE DATE

All About Preemies

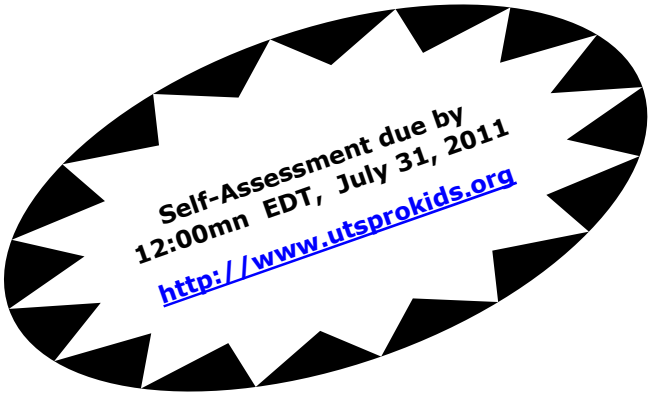
A Conference for First Steps Providers

Friday, July 8, 2011

Fort Benjamin Harrison Conference Center

Indianapolis, Indiana

UTS Programmatic Training
ProKids, Inc.
6923 Hillsdale Ct.
Indianapolis, IN 46250



Legislative Changes to Indiana First Steps Program

The 2011 General Assembly has adjourned. Several changes to First Steps rules were included in HB1001, the Budget Bill. These include:

- The First Steps state appropriation for the next 2 years is $6,149,513 annually. This is the same amount that First Steps received from the state in the previous budget and only represents one funding source. Federal appropriations, insurance, Medicaid and family cost participation make up the remainder.
- Changes to insurance reimbursement, for non-ERISA plans (those plans under state and not federal control, such as fully insured plans, public employee and university employee plans) in place of a fee for service billed to insurance, a monthly fee established by DDRS, will be charged instead of processing individual claims.
- “per unit of treatment” was defined as an increment of 15 minutes
- The maximum monthly cap on family co-pays has been doubled and all fees will be assessed in 15 minute increments.
- Increases the per unit of treatment cost for incomes that are 651%- >850% of federal poverty level.
- Adds a new section outlining what DDRS may do for any amount owed that is more than 60 days past due:
    1. Hold the amount owed from and state tax refund
    2. Terminate services, but not until the agency
        - Has provided written notice stating the amount owed, the payment necessary to prevent termination of services and advising the family that they may contact the agency for assistance or to negotiate an alternative payment arrangement or to recalculate the amount owed.

You can review these changes in the Enrolled Act for HB1001 at: http://www.in.gov/legislative/bills/2011/HE/HE1001.1.html.

No change was made to 6) must require the division to waive the family's monthly copayments in any month for those services for which it receives payment from the family's health insurance coverage.